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KANSAS HEALTH POLICY AUTHORITY

Testimony on:
Response to LPA Audit

Presented to:
Senate Public Health and Welfare Committee

By
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Ms. Barbara J. Hinton
Legislative Post Auditor
800 SW Jackson Street, Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

The Kansas Health Policy Authority (KHPA) has received the Legislative Division of Post Audit's (LPA) report regarding its audit of statewide medical expenditures in the Medicaid program. I appreciate the opportunity to respond to the findings and recommendations included in the report.

According to Appendix A of the report, the audit was requested as part of ongoing compliance and control audits authorized by the Legislative Post Audit Committee to better address the risk of fraud and abuse. The audit applies a technique described as "data mining" to analyze the entire universe of Medicaid claims paid between October 1, 2005 and September 30, 2006, which includes approximately $2 billion worth of paid claims. The data mining techniques used in the audit are intended to identify unusual patterns in large data sets in order to increase the likelihood of finding fraud and abuse. As described by the LPA, the process is designed to increase the likelihood that fraud and abuse will be found. We agree. The value of this process is that it can significantly narrow the search for fraud and abuse in known areas of vulnerability so that auditors and program staff can make better use of the time required to follow-up and confirm each finding.

Our assessment of LPA's findings suggest that this initial data-mining exercise identified less than one-half of one percent of Medicaid spending in federal fiscal year 2006 as "suspicious," e.g., "unusual" and "more likely to be problematic." We are pleased that the audit revealed no systemic problems warranting significant and immediate action, and welcome the recommendations to help improve payment accuracy. Although most of the audit period occurs prior to the time that the KHPA assumed responsibility for managing the Medicaid program – July 1, 2006 – we recognize the value of LPA's efforts and agree that many of the claims deserve a second look to determine whether a pattern of fraud or abuse exists. In responding to this audit, KHPA staff did have an opportunity to take a look at a small fraction of the suspicious claims identified by LPA's initial screens and found a mixture of results. Some suspicious claims were found to represent erroneous payments or directly indicated abusive billing practices, while others were found to be in full compliance with Medicaid payment and eligibility rules. These findings are consistent with KHPA program experience and confirm the value of a multi-stage process to identify fraud, abuse, and erroneous payments.

KHPA Comments on LPA Conclusions and Recommendations

The audit examined whether there appears to be significant instances of fraud, abuse, or non-compliance within the State's Medicaid expenditures. The report indicates that the data mining techniques found suspicious Medicaid claims in the following areas:

Clients whose income exceeded the program's eligibility requirements. LPA matched beneficiary eligibility data from the Medicaid Management Information System (MMIS) to Department of Labor quarterly income data. The audit identified 10,000 beneficiaries whose income appeared to exceed program limits. Further investigation by KHPA indicates that only 20% of the sampled cases should be suspected of having incomes that exceed the income guidelines. The analysis in the audit relied on calculating a family's monthly income using the Department of Labor's data and dividing it by three. However, eligibility must be determined based on the applicant's income information at the time of application, not on an average of what past earnings had been.

The audit recommends that KHPA develop systems to periodically compare a list of existing Medicaid clients to the Department's income data to identify anyone who no longer appears to be eligible and have the appropriate staff follow up to make a final eligibility determination.

KHPA agrees with the recommendation and will explore the costs of developing or acquiring tools to perform the periodic matches. To make such a data-matching exercise cost-effective, KHPA would need to develop additional filters to narrow the suspected number of families with higher than allowed incomes to a reasonable number that could feasibly be investigated.

Clients who didn't provide a valid Social Security number: LPA identified 266 clients who received services without providing a valid Social Security number.

The audit recommended that KHPA should work with its contractors to create system edits that prevent new clients from being added to the system without a valid Social Security number.

KHPA disagrees with the recommendation. The federal requirement is for all persons who apply for Medicaid to provide a Social Security number or proof of application for a number to receive Medicaid benefits. Further investigation of some of the 266 clients revealed several cases where an individual was given a chance to apply for a Social Security number, but the case was closed after they failed to produce one. The medical coverage received during the short period the case was open is a legitimate Medicaid expenditure under the federal rules and does not constitute an overpayment.

In addition, the State eligibility system, KAECSES, already has a number of edits to prevent the entering of an invalid Social Security number. KAECSES is the eligibility system of record and it

would be inappropriate for the claims processing system (MMIS) to edit the eligibility file submitted by the eligibility system of record.

Providers who charged an excessive share of office or emergency room visits at more expensive levels of service (also known as "upcoding"). The audit reviewed claims data to identify "upcoding" without considering all of the relevant factors that make claims for the same type of providers similar or different. When payments to providers for comparable procedure codes are compared without considering the medical needs of the consumer, there can be many false positive results for excessive charges. For instance, a 24 year old male with a cold will take less of a physician's time than a 24 year old male with a heart defect. If the diagnosis, or illness level, of the consumer is not considered, the claim for the consumer with the heart defect could be interpreted as "upcoded" even for the same type for procedure.

The audit recommended that KHPA should develop a system to review doctors' billing patterns on a regular basis and have the appropriate staff follow up on suspicious cases as necessary.

KHPA contracts with Electronic Data Systems (EDS) to provide Surveillance and Utilization reviews services (SURS) and a Fraud and Abuse Detection system (FAD). EDS uses a provider profiling tool that is used throughout the insurance industry. This approach provides a multi-dimensional analysis rather than the one-dimensional analysis used in LPA's data mining exercise. The profiling tool considers age, sex, and illness to compare the average cost for a consumer within a group of similar consumers to develop provider billing profiles. Nurses, using their clinical expertise, can then take these results and compare physicians to one another based on the expected cost of that consumer's care. Findings of overpayments are pursued via recoupment of the overpayment. Cases of suspected fraud are referred to the Attorney General's office for further handling. KHPA believes the existing system and process of profiling providers meets the intent of the audit recommendation..

Clients who received prescriptions for powerful painkillers and other controlled substances from five or more doctors. The audit recommends that KHPA should develop a system to review clients' prescription patterns on a regular basis and have the appropriate staff follow up on suspicious cases as necessary.

KHPA currently has such a system in place through the EDS contract, SURS, FAD, and prescription profiling. KHPA reviewed a number of the suspicious cases identified in the audit and found reasonable explanations for many of those cases, e.g., some of the patients were terminally ill and the prescribers were different doctors part of the same physician group.

Overlapping services, services rendered after death, and excessive amount of services rendered in a single visit. The audit recommends that KHPA work with its contractors to review its system edits and other control procedures, with particular emphasis on overlapping claims and client deaths. In addition, KHPA should develop a system to periodically compare a list of existing

Medicaid clients to the death certificate data from the Kansas Department of Health and Environment (KDHE) to identify clients who may have died, and have the appropriate staff follow up to as necessary.

KHPA agrees with the recommendation. KHPA is in the process of refining the current death data match process we have in place with KDHE.

We appreciate the effort of Levi Bowles and Scott Frank in conducting the audit and being willing to discuss early drafts of the audit. They were responsive in responding to our concerns. Thank you for the opportunity to respond to the draft audit report.

Sincerely,

Dr. Andrew Allison, Deputy Director
Medicaid Director

"Addendum: The final version of the LPA audit includes changes in their recommendation for executive action to address potential eligibility issues associated with Medicaid enrollees that do not have a valid Social Security Number recorded in KHPA's administrative records. KHPA agrees with LPA's modified recommendation, which addresses concerns that KHPA had raised in our original response to the version of the recommendation LPA shared with us prior to the Legislative Post Audit Committee's December 19, 2008 hearing on the subject. KHPA acknowledges LPA's responsiveness in addressing our concerns with earlier drafts of their audit, and looks forward to working with LPA to address remaining issues identified in the audit."